

PRE-HOSPITAL PATIENT CARE REPORT

HEALTH DEPARTMENT FORM #

N 3582701

Incident # Incident in CITY COUNTY of: FIPS DATE Agency Agency # Unit # Agency Use # Incident Location

LOCATION TYPE				TYPE OF SERVICE		INCIDENT DISPOSITION			
1	Home/Residence	7	Public Building	1	Scene	1	Treated, Transported EMS	6	Patient Refused Care
2	Farm	8	Residential Institution	2	Unsched Interfacility Transfer	2	Treated, Transferred Care	7	Dead at Scene
3	Mine/Quarry	9	Educational Institution	3	Sched Interfacility Transfer	3	Treated, Transported Private Vehicle	8	Cancelled
4	Industrial Place/ Premises	10	Other Specified Location	4	Standby	4	Treated and Released	9	No Patient Found
		11	Unspecified Location	5	Rendezvous		NA	Not Applicable	
5	Recreation Place	NA	Not Applicable	NA	Not Applicable	5	No Treatment Required	U	Unknown
6	Street/Highway	U	Unknown	U	Unknown				

TIMES (24 Hour Format)

<input type="text"/>	<input type="text"/>	<input type="text"/>	TIME OF CALL
<input type="text"/>	<input type="text"/>	<input type="text"/>	DISPATCHED
<input type="text"/>	<input type="text"/>	<input type="text"/>	RESPONDING
<input type="text"/>	<input type="text"/>	<input type="text"/>	ARRIVE SCENE
<input type="text"/>	<input type="text"/>	<input type="text"/>	ARRIVE PATIENT
<input type="text"/>	<input type="text"/>	<input type="text"/>	LEAVE SCENE
<input type="text"/>	<input type="text"/>	<input type="text"/>	ARRIVE DESTINATION
<input type="text"/>	<input type="text"/>	<input type="text"/>	LEAVE DESTINATION
<input type="text"/>	<input type="text"/>	<input type="text"/>	RETURN SERVICE

AIC ID # FR EMT ST CT I P RN MD OTH NA Other Agency Units Responding

Att 1 ID # FR EMT ST CT I P RN MD OTH NA Unit #

Att 2 ID # FR EMT ST CT I P RN MD OTH NA Unit #

Operator ID # FR EMT ST CT I P RN MD OTH NA Unit #

Operator ID # FR EMT ST CT I P RN MD OTH NA Unit #

Patient's
Name SSN Patient's FIPS Patient's
Physician

Address AGE Year Mon Other Personnel

City State Zip - AGE Day Unk Fire

Spouse Parent/Guardian DOB Law Officer

Other Address WT LB KG

Allergies Race Code

Med Gender Code

TYPE OF CALL				PRE-EXISTING CONDITION					
1	Accident/Industrial/Construction	7	Mutual Aid	1	Asthma	7	Chronic Renal Failure	0	Other:
2	Accident/MVC	8	Public Service	2	Diabetes	8	Cancer		
3	Assault	9	Standby	3	Tuberculosis	9	Hypertension		
4	Fire	10	Transport/Routine	4	Emphysema	10	Psychiatric Problems		
5	Injury Not Listed	0	Other:	5	Chronic Resp Failure	11	Seizure Disorder	NA	Not Applicable
6	Medical Emergency			6	Heart Disease	12	Tracheostomy	U	Unknown

HISTORY OF PRESENT ILLNESS/PHYSICAL EXAM/OTHER INFORMATION:

		1 min APGAR: <input type="text"/>		5 min APGAR: <input type="text"/>		BURN %: <input type="text"/>					
Time	LOC	Pulse	Respirations	BP	Perfusion	Pupils	EKG	Defib Joules	Pulse Ox	Glucose	GCS Score
	<input type="checkbox"/> Alert <input type="checkbox"/> Voice <input type="checkbox"/> Pain <input type="checkbox"/> Unresp	Rate: <input type="text"/> <input type="checkbox"/> Not Obtained <input type="checkbox"/> Unable To	Rate: <input type="text"/> <input type="checkbox"/> Normal <input type="checkbox"/> Increased, not labored <input type="checkbox"/> Increased/labored OR Decreased/fatigued <input type="checkbox"/> Absent	<input type="checkbox"/> Palpated <input type="checkbox"/> Not Obtained <input type="checkbox"/> Unable To	<input type="checkbox"/> Normal <input type="checkbox"/> Decreased <input type="checkbox"/> Not Obtained	<input type="checkbox"/> PERL <input type="checkbox"/> R > L <input type="checkbox"/> L > R <input type="checkbox"/> DIL <input type="checkbox"/> CON <input type="checkbox"/> UNREACT					EYE: VERBAL: MOTOR: TOTAL:
	<input type="checkbox"/> Alert <input type="checkbox"/> Voice <input type="checkbox"/> Pain <input type="checkbox"/> Unresp	Rate: <input type="text"/> <input type="checkbox"/> Not Obtained <input type="checkbox"/> Unable To	Rate: <input type="text"/> <input type="checkbox"/> Normal <input type="checkbox"/> Increased, not labored <input type="checkbox"/> Increased/labored OR Decreased/fatigued <input type="checkbox"/> Absent	<input type="checkbox"/> Palpated <input type="checkbox"/> Not Obtained <input type="checkbox"/> Unable To	<input type="checkbox"/> Normal <input type="checkbox"/> Decreased <input type="checkbox"/> Not Obtained	<input type="checkbox"/> PERL <input type="checkbox"/> R > L <input type="checkbox"/> L > R <input type="checkbox"/> DIL <input type="checkbox"/> CON <input type="checkbox"/> UNREACT					EYE: VERBAL: MOTOR: TOTAL:
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MECHANISM OF INJURY		SIGNS AND SYMPTOMS		CLINICAL ASSESSMENT		INJURY DESCRIPTION										AGENCY USE			
1	Aircraft Related Accident	1	Abdominal Pain	1	Abdominal Pain/Problems	Face Head Neck Spine Thorax Hand, Arm Abdomen Foot, Leg Body region unspecified N/A <input type="checkbox"/>	Skull Base Burn Injury Laceration Decubity Fracture/Strap Concussion Amputation Cuts Burn												
2	Assault	2	Back Pain	2	Airway Obstruction														
3	Bicycle Accident	3	Bloody Stools	3	Allergic Reaction														
4	Bites	4	Breathing Difficulty	4	Altered Level of Consciousness														
5	Burns/Thermal/Chemical	5	Cardioresp Arrest	5	Behavioral/Psychiatric Disorder														
6	Chemical Poisoning	6	Chest Pain	6	Cardiac Arrest														
7	Drowning	7	Choking	7	Cardiac Rhythm Disturbance														
8	Drug Poisoning	8	Diarrhea	8	Chest Pain/Discomfort														
9	Electrocution (non-lightning)	9	Dizziness	9	Diabetic														
10	Excessive Cold	10	Ear Pain	10	Electrocution														
11	Excessive Heat	11	Eye Pain	11	Hyperthermia														
12	Falls	12	Fever/Hyperthermia	12	Hypothermia														
13	Firearm Injury	13	Headache	13	Hypovolemia/Shock														
14	Lightning	14	Hypertension	14	Inhalation Injury (Toxic Gas)														
15	Machinery Accidents	15	Hypothermia	15	Obvious Death														
16	Mechanical Suffocation	16	Nausea	16	Poisoning/Drug Ingestion														
17	MVC-Non-Public Road/Off Road	17	Paralysis	17	Pregnancy/OB Delivery														
18	MVC-Public Road	18	Palpitations	18	Respiratory Arrest														
19	Pedestrian Traffic Accident	19	Preg./Childbirth/Miscarriage	19	Respiratory Distress														
20	Radiation Exposure	20	Seizures/Convulsions	20	Seizure														
21	Smoke Inhalation	21	Syncopal	21	Smoke Inhalation														
22	Sports Injury	22	Unresponsive/Unconscious	22	Stings/Venomous Bites														
23	Stabbing	23	Vaginal Bleeding	23	Stroke/CVA														
24	Venomous Stings (plants, animals)	24	Vomiting	24	Syncopal/Fainting														
25	Water Transport Accident	25	Weakness (malaise)	25	Traumatic Injury														
O	Other:	O	Other:	26	Vaginal Hemorrhage														
NA	Not Applicable			27	General Illness														
U	Unknown			O	Other:														
				U	Unknown														

PROCEDURES		ID Number	PROCEDURES - AIRWAY		Size	Loc.	Attempts	#Suc	Time	ID Number
1	Assisted Ventilation (BVM)		3	Chest Decompression						
2	Positive Pressure Ventilation LPM:		4	Cricothyrotomy						
7	Nasal Airway LPM:		5	EGTA/EOA/PLT/CBT						
9	Oral Airway LPM:		6	ET						
10	Nasal Cannula LPM:		8	NG Tube						
11	Oxygen Mask LPM:		IV ACCESS							
12	Backboard			Location	Gauge	Atpts	Suc	Time	Fluid/Type	Vol./Rate ID Number
13	Bleeding Controlled		1							
14	Burn Care		2							
15	CPR		3							
16	ECG Monitoring		4							
17	Defibrillation/Cardioversion (AED)		5							
18	Immobilization - Extremity		MEDICATION							
19	Immobilization - Spine			Dose/Route	Time	ID Number	Dose/Route	Time	ID Number	
20	Immobilization - Traction Splint		1							
21	Intravenous Catheter		2							
22	Intraosseous Catheter		3							
23	Intravenous Fluids		4							
24	MAST/PSAG		5							
25	Medication Administration		6							
26	OB Care/Delivery		7							
27	Pacing		8							
O	Other		9							
NA	Not Applicable		10							

TREATMENT AUTHORIZATION		PHYSICIAN'S NOTES/ORDERS/SIGNATURE:										IV BOX: OLD# NEW#			
1	Standing Orders											OLD# NEW#			
2	On-line											OLD# NEW#			
3	On-scene											DRUG BOX: OLD# NEW#			
4	Transfer Orders														
5	DNR														
NA	Not Applicable														
U	Unknown														
		PHYSICIAN DEA#:										NARCOTICS ACCOUNTED FOR:			

MV IMPACT		SAFETY EQUIPMENT		LEVEL OF CARE PROVIDED		DESTINATION TRANSFERRED		DESTINATION DETERMINATION		Receiving Facility #	
1	Head-on	1	None Used	7	Helmet	1	Home	1	Closest Facility		
2	Lateral	2	Shoulder Only	8	Eye Protection	2	Police/Jail	2	Patient/Family Choice		
3	Ejection	3	Lap Only	9	Protective Clothing	3	Medical Office/Clinic	3	Patient/Physician Choice		
4	Rear	4	Shoulder/Lap	10	Pers. Float. Device	4	Other EMS Responder (Ground)	4	Managed Care		
5	Rollover	5	Safety Seat	NA	Not Applicable	5	Other EMS Responder (Air)	5	Law Enforcement Choice		
6	Rotation	6	Air Bag	U	Unknown	6	Hospital	6	Protocol		
NA	Not Appl					7	Morgue	7	Specialty Resource Center		
U	Unknown					NA	Not Applicable	8	On-line Medical Direction		
								9	Diversion		
								O	Other:		
								NA	Not Applicable		